

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2
3 In the Matter of:

4 **DONALD REYNOLDS SCHIEVE, M.D.**

5 Holder of License No. 18602
6 For the Practice Medicine
7 In the State of Arizona,

Case Nos. MD-97-0440

MD-98-0048

MD-98-0129

MD-01-0089

MD-01-0 338

**CONSENT AGREEMENT AND
ORDER FOR SUSPENSION,
PRACTICE RESTRICTION,
AND PROBATION**

10
11 **CONSENT AGREEMENT**

12 **RECITALS**

13 In the interest of a prompt and judicious settlement of the above-captioned matter
14 before the Arizona State Board of Medical Examiners (Board) and consistent with the
15 public interest, statutory requirements and responsibilities of the Board and under A.R.S.
16 § 41-1092.07(F)(5), Donald Reynolds Schieve, M.D. (Respondent), holder of license
17 number 18602 to practice allopathic medicine in the State of Arizona, and the Board
18 enter into the following Recitals, Findings of Fact, Conclusions of Law and Order
19 ("Consent Agreement") as the final disposition of this matter.
20
21

22 1. Respondent has read and understands this Consent Agreement as set forth
23 herein, and has had the opportunity to discuss this Consent Agreement with an attorney
24 or has waived the opportunity to discuss this Consent Agreement with an attorney.
25 Respondent voluntarily enters into this Consent Agreement for the purpose of avoiding
26

1 the expense and uncertainty of an administrative hearing.

2 2. Respondent understands that he has a right to a public administrative
3 hearing concerning each and every allegation set forth in the above-captioned matter, at
4 which administrative hearing he could present evidence and cross-examine witnesses.
5 By entering into this Consent Agreement, Respondent freely and voluntarily relinquishes
6 all right to such an administrative hearing, as well as all rights of rehearing, review,
7 reconsideration, appeal, judicial review or any other administrative and/or judicial
8 action, concerning the matters set forth herein. Respondent affirmatively agrees that this
9 Consent Agreement shall be irrevocable.

10 3. Respondent agrees that the Board may adopt this Consent Agreement or
11 any part of this agreement, under A.R.S. § 32-1451(G)(5). Respondent understands that
12 this Consent Agreement or any part of the agreement may be considered in any future
13 disciplinary action against him.

14 4. Respondent understands that this Consent Agreement does not constitute a
15 dismissal or resolution of other matters currently pending before the Board, if any, and
16 does not constitute any waiver, express or implied, of the Board's statutory authority or
17 jurisdiction regarding any other pending or future investigation, action or proceeding.
18 Respondent also understands that acceptance of this Consent Agreement does not
19 preclude any other agency, subdivision or officer of this state from instituting other civil
20 or criminal proceedings with respect to the conduct that is the subject of this Consent
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1 Agreement.

2 5. Respondent acknowledges and agrees that, upon signing this Consent
3 Agreement and returning this document to the Board's Executive Director, Respondent
4 may not revoke his acceptance of the Consent Agreement or make any modifications to
5 the document, regardless of whether the Consent Agreement has been issued by the
6 Executive Director. Any modification to this original document is ineffective and void
7 unless mutually approved by the parties in writing.
8

9
10 6. Respondent understands that the foregoing Consent Agreement shall not
11 become effective unless and until adopted by the Board and signed by its Executive
12 Director.
13

14 7. Respondent understands and agrees that if the Board does not adopt this
15 Consent Agreement, he will not assert as a defense that the Board's consideration of this
16 Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.
17

18 8. Respondent understands that this Consent Agreement is a public record
19 that may be publicly disseminated as a formal action of the Board, and shall be reported
20 as required by law to the National Practitioner Data Bank and the Healthcare Integrity
21 and Protection Data Bank.
22

23 9. Respondent understands that any violation of this Consent Agreement
24 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(25)(r)([v])iolating a
25 formal order, probation, consent agreement or stipulation issued or entered into by the
26

1 board or its executive director under the provisions of this chapter) and may result in
2 disciplinary action pursuant to A.R.S. § 32-1451.
3

4
5 ACCEPTED BY:

6
7 DATED: September 8, 2003
8

Donald Reynolds Schieve M.D.
Donald Reynolds Schieve, M.D.

9
10 REVIEWED AND APPROVED AS TO FORM
11 BY:

12 Richard W. Chubb
13 Counsel for Respondent

14 FINDINGS OF FACT

15 By stipulation of the parties, the following Findings of Fact, Conclusions of Law
16 and Consent Order are entered for final disposition of the matters described therein.

17 Respondent acknowledges that sufficient evidence exists for the Board to make the
18 following Findings of Fact:
19

- 20 1. The Board is the duly constituted authority for the regulation and control of the
21 practice of allopathic medicine in the State of Arizona.
22
23 2. Respondent is the holder of License No. 18602 for the practice of allopathic
24 medicine in the State of Arizona.
25
26 3. On November 2, 1998, the Board entered an Interim Order restricting

1 from practicing medicine in the State of Arizona during the pendency of the
2 following investigations. Respondent has not practiced medicine since the date of
3 that Interim Order.
4

5 **Case Number MD-97-0440**

- 6 4. In May 1997, the Board initiated case number MD-97-0454 after being notified
7 that the State of Nevada had entered into a Stipulation with Respondent to revoke
8 his license; stay the revocation; and place Respondent on probation for five years
9 with terms and conditions, including placing his license on inactive status during
10 the term of the probation; paying the Board in Nevada \$7,500; and receiving a
11 public reprimand. The Nevada Board action was the result of an investigation
12 into Respondent's practice of performing "phenol face peels."
13
14 5. Respondent had hired a Ronald Bennett to teach Respondent the formula and
15 technique for performing "exodermology", a face-peeling procedure and helped
16 set up clinics in Las Vegas and Los Angeles. Although Bennett closely assisted
17 Respondent in doing the procedures and Bennett's business card identified him as
18 a doctor, Bennett was not licensed as a physician in the United States. This
19 association started the Nevada investigation.
20
21 6. The Nevada investigation resulted in a Complaint alleging 35 violations including
22 signing blank prescription forms; engaging in conduct intended to deceive; failure
23 to maintain medical records relating to diagnosis, treatment and care of a patient;
24
25
26

1 altering medical records of a patient; falsifying records of health care; writing
2 prescriptions for controlled substances for a patient without an appropriate
3 examination which confirms the medical necessity for the controlled substances;
4 acquiring controlled substance from a pharmacy by misrepresentation, fraud,
5 deception or subterfuge; aiding, assisting, employing or advising any unlicensed
6 person to engage in the practice of medicine; and performing services which
7 licensee knows or has reason to know he is not competent to perform.
8

9
10 7. Respondent entered into a stipulation with the Nevada Board that he had engaged
11 in a medical practice of performing "phenol face peels" together with Mr.
12 Bennett, an individual not licensed to practice medicine in the State of Nevada,
13 and that the medical practice of "phenol face peels" have no relationship to his
14 practice as an ophthalmologist.
15

16
17 8. The investigation sustained the allegation that Respondent violated A.R.S. § 32-
18 1401.25(o), action taken against a doctor of medicine by another licensing or
19 regulatory jurisdiction.
20

21 9. Respondent, in May 1998, voluntarily entered into a drug rehabilitation program.
22 He was sent to Charter Hospital, in Atlanta, Georgia for Valium detoxification.
23 After approximately ten days, he was sent to the Rush Behavioral Health Center
24 in Downers Grove, Illinois, where he completed a ten week program. Respondent
25 has been under contract with the Nevada State Board of Medical Examiners
26

1 Diversion Program, attending 12-step meetings and subjected to random urine
2 drug testing.

3
4 **Case Number MD-98-0048**

- 5 10. Investigation MD-98-0079 was commenced after the Kingman Regional Medical
6 Center revoked Respondent's medical staff privileges on January 13, 1998, based
7 on the action taken by the Nevada Board and Respondent's failure to report the
8 pending complaint in Nevada to the hospital.

9
10 **Case Number MD-98-0129**

- 11 11. Investigation MD-98-0160 was commenced after the Board was notified that
12 Arizona Physicians IPA had denied credentialing to Respondent as a result of his
13 malpractice history and the Board actions in Arizona and Nevada.

14
15 **Case Number MD-01-0089**

- 16 12. The Board initiated case number MD-01-0089 January 30, 2001, after receiving
17 information regarding a malpractice settlement against Respondent in a medical
18 malpractice case brought by a former patient, RT, in the State of Arizona.
19
20 13. On April 22, 1992, Patient RT presented to Respondent for evaluation of a lump
21 under his left eye. RT had a history of previous tear duct surgery. Respondent
22 referred RT to Dr. Janice Eileen Eggert, MD, for further evaluation.
23
24 14. On June 24, 1992, Dr. Eggert examined RT and assessed that the lump was either
25 a scar or mass from previous surgery. Dr. Eggert examined RT again on August
26

- 1 5, 1992, irrigated the nasolacrimal duct and instructed RT to return in one month.
- 2
- 3 15. On September 9, 1992, Dr. Eggert performed an excisional biopsy on the lump
- 4 and provided the specimen to Respondent, a Board-certified pathologist as well as
- 5 an ophthalmologist, for analysis.
- 6 16. Respondent performed a gross analysis and determined the specimen to be benign
- 7 and informed RT accordingly.
- 8
- 9 17. RT continued to have problems with the mass and was eventually determined to
- 10 have adenoid cystic carcinoma.
- 11
- 12 18. Respondent admitted to discarding the specimen after completing only a gross
- 13 examination with no microscopic examination.
- 14 19. Respondent failed to record the results of the examination of the biopsy nor
- 15 discussions about the biopsy with either RT or Dr. Eggert.
- 16
- 17 20. Respondent did not have any follow-up with RT after the biopsy was performed.
- 18 21. Respondent fell below the standard of care because he did not adequately
- 19 communicate with other healthcare providers regarding the performance of a
- 20 biopsy; failed to communicate the results of the biopsy with the patient; and he
- 21 failed to properly examine, test, evaluate and treat the patient's condition and fell
- 22 below the standard of care for a pathologist.
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Case Number MD-01-0338

- 1 22. The Board initiated case number MD-01-0338 May 30, 2001, after receiving
2 information regarding a malpractice settlement against Respondent in a medical
3 malpractice case brought by a former patient, RJW, in the State of Arizona.
- 4
- 5 23. RJW presented to Respondent on October 19, 1994 regarding a possible cataract
6 in his left eye. Examination showed poor vision in the left eye due to posterior
7 subcapsular cataract with moderate nuclear sclerosis. The left eye was otherwise
8 healthy. Respondent recommended surgery and the surgery was completed on
9 December 14, 1994.
- 10
- 11 24. Respondent failed to note in his charts any discussion had with RJW regarding
12 possible complications. The results of the cataract surgery were good and there
13 were no major complications.
- 14
- 15 25. The surgical procedure included placement of 19.5 diopter lens in the posterior
16 chamber that was calculated to produce minimal myopia of 0.5 diopters.
- 17
- 18 26. RJW continued to have vision problems (blurring) and dry eye. On January 4,
19 1995, less than three weeks after the surgery, Respondent noted that he was
20 considering a YAG laser procedure. In February, Respondent thought that
21 moderate thickening of the posterior capsule was possibly causing the blurred
22 vision.
- 23
- 24 27. Respondent's record does not include an informed consent form indicating that
25 RJW was adequately informed prior to the procedure and does not include any
26

1 notations indicating that such a discussion was had with the patient. There was no
2 refraction completed to find out how well the patient could see with best spectacle
3 correction prior to performing the YAG laser and no finding of a cloudy capsule
4 was described in Respondent's records.
5

6 28. Absent severe clouding in the capsule, which is not described in Respondent's
7 records, allowing the eye to substantially heal first and a trial at spectacles to see
8 if that would satisfy the patient's visual wishes is indicated prior to performing
9 the laser treatment.
10

11 29. It was the laser opening in the posterior capsule that cased the later problem with
12 the lens exchange. Had a refraction been done first, the option of a lens exchange
13 could have been considered before performing the YAG capsulotomy.
14

15 30. Respondent performed below the standard of care by inadequate documentation,
16 by his timing of the laser treatment, by not pursuing any alternatives and by
17 failing to provide adequate information to the patient pre-operatively.
18

19 31. On May 23, 1995, Respondent performed a lens exchange in the left eye. RJW
20 had insisted that the myopic post-operative refraction was unacceptable and had
21 consulted an ophthalmologist in California who told him to correct his vision with
22 glasses. In spite of this, Respondent performed the lens exchange.
23

24 32. During the surgery, vitreous prolapsed into the anterior chamber, necessitating a
25 vitrectomy and the use of an anterior chamber lens. There was no compelling
26

- 1 medical reason to do this implant lens exchange and there is no record
2 Respondent attempted or even considered appropriate safer visual corrective
3 alternatives such as glasses, contact lenses or even RK surgery.
4
- 5 33. Respondent utilized a Weck-cel sponge in performing the vitrectomy. This is a
6 primitive, less safe and less effective way to remove the prolapsed vitreous. In
7 the Weck-cel method, the sponge is used to engage and ull up the vitreous so that
8 it can be cut off with a scissors. This may cause the vitreous to pull on its
9 attachment to the retina with subsequent retina problems such as retinal tear and
10 detachment. The Weck-cel method is used in emergency situations when no
11 mechanical vitreous cutter is available. These cutters should be and usually are
12 available when intraocular lens surgery is done, especially when the risk of
13 vitreous prolapse or loss is high such as in this case.
14
- 15 34. A Weck-cel sponge is less effective and more often leaves strands of vitreous in
16 the wound which later fibrose, contract and cause retinal traction and
17 inflammation leading to Cystoid Macular Edema (CME). Vitreous remained in
18 the anterior chamber after Respondent's surgery on RJW.
19
- 20 35. Because of the remnants of vitreous, Respondent elected to do another vitrectomy
21 on June 6, 1995 to prevent further complications. The following week, RJW's
22 vision was 20/30+, but it decreased at the three-week visit and Respondent began
23 treating RJW for CME.
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- 1 36. Treatment continued over several months, with periods of improvement while
2 RJW was on medication and vision deterioration when medication was
3 discontinued. Eventually, in May, 1996, RJW was referred to a vitreoretinal
4 surgeon, who performed surgery to repair a retinal tear and detachment.
5
- 6 37. Respondent violated the standard of care by performing a lens exchange in an eye
7 with a well-fixed intraocular lens that was causing no problems and in the
8 presence of an open posterior capsule for the intended purpose of correcting a
9 small to moderate refractive error, thus inappropriately exposing the eye to the
10 known significant risk of vitreous loss and significant secondary retinal
11 complications.
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14 Mitigation

- 15 38. Respondent completed the terms and conditions imposed by the State of Nevada
16 regarding his medical license. Respondent completed the Special Purpose
17 Examination (SPEX) on January 8, 1999 and received a passing score of 78.
18
- 19 39. Respondent entered treatment at Talbott Recovery in Atlanta, Georgia in May,
20 1998. He was transferred to Rush Behavioral Health in Chicago, Illinois where
21 he successfully completed treatment in August, 1998.
22
- 23 40. Respondent has been subject to a voluntary contract with the Nevada Health
24 Professionals Assistance Foundation since August 22, 1998. He has attended a
25 weekly Caduseus group as well as 12-step recovery groups. He has been
26

1 subjected to random drug screening since the beginning of that contract and all
2 results have been negative. He has been compliant with all aspects of his
3 contract.
4

- 5 41. Respondent has maintained his competency by obtaining necessary Continuing
6 Medical Education credits during the term of his suspension.
7

8 CONCLUSIONS OF LAW

- 9 1. The Board possesses jurisdiction over the subject matter and over Respondent.
10 2. The conduct and circumstances described above, in paragraphs 4-11, constitute
11 unprofessional conduct pursuant to A.R.S. § 32-1401(25)(o) action taken against a
12 doctor of medicine by another licensing or regulatory jurisdiction due to that
13 doctor's mental or physical inability to engage safely in the practice of medicine,
14 his medical incompetence or for unprofessional conduct.
15
16 3. The conduct and circumstances described above, in paragraphs 4-37, constitute
17 unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q), (any conduct or
18 practice which is or might be harmful or dangerous to the health of the patient or
19 the public).
20
21 4. The conduct and circumstances described above, in paragraphs 4-11, constitute
22 unprofessional conduct pursuant to A.R.S. § 32-1401(25)(cc) maintaining a
23 professional connection with or lending one's name to enhance or continue the
24 activities of an illegal practitioner of medicine.
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1 5. The conduct and circumstances described above, in paragraphs 12-21 and 22-37,
2 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(II), (conduct
3 that the board determines is gross negligence, repeated negligence or negligence
4 resulting in harm to or the death of a patient).
5

6 CONSENT ORDER

7
8 **IT IS THEREFORE ORDERED** that:

9 1. License No. 18602, issued to Respondent Donald Reynolds Schieve, M.D.,
10 is suspended for a period of **12 months**. Respondent shall be credited for the time he
11 has already served under the prior Order. Respondent Donald Reynolds Schieve, M.D.,
12 License No. 18602, shall Respondent shall be restricted to clinical practice of medicine
13 only and shall not perform any surgeries requiring conscious or unconscious sedation.
14 This restriction shall remain in effect until the Respondent applies to the Board and the
15 Board approves Respondent's return to practice in these areas.
16
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18
19 2. Respondent is placed on probation for **2 years** with the following terms
20 and conditions. Upon any violation of a probationary term, after giving notice and the
21 opportunity to be heard, the Board shall suspend respondent's license for the period
22 stated above. If an investigation involving an alleged violation of the probation is
23 initiated but not resolved prior to the termination of the probation, the Board shall have
24 shall have continuing jurisdiction and the period of probation shall extend until the
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26

1 matter is final.

2 3. Respondent Donald Reynolds Schieve, M.D., License No. 18602 shall be
3
4 subject to a chart review to be conducted by Board staff or its agents within **6 months**
5 **and at the end of 1 year** of the re-activation of his license. Based upon the chart
6 review, the Board retains jurisdiction to take additional disciplinary or remedial action.
7

8
9 4. Respondent Donald Reynolds Schieve, M.D., License No. 18602 shall
10 within **1 year** of the effective date of this Order, complete a course in Ethics pre-
11 approved by Board Staff and provide Board staff with satisfactory proof of attendance.
12

13
14 5. Respondent shall submit quarterly declarations under penalty of perjury on
15 forms provided by the Board, stating whether there has been compliance with all the
16 conditions of probation. The declarations shall be submitted on or before the 15th of
17 March, June, September and December of each year.
18

19
20 6. In the event respondent should leave Arizona to reside or practice outside
21 the State or for any reason should respondent stop practicing medicine in Arizona,
22 respondent shall notify the Executive Director in writing within ten days of departure
23 and return or the dates of non-practice within Arizona. Non-practice is defined as any
24 period of time exceeding thirty days in which respondent is not engaging in the practice
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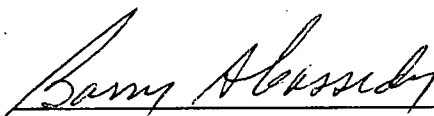
1 of medicine. Periods of temporary or permanent residence or practice outside Arizona or
2 of non-practice within Arizona, will not apply to the reduction of the probationary
3 period.
4

5 DATED AND EFFECTIVE this 10th day of October, 2003.



ARIZONA MEDICAL BOARD

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Barry A. Cassidy, Ph.D., P.A.-C.
Executive Director

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Original of the foregoing filed this
10th day of October, 2003, with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed Copy of the foregoing mailed
mailed by U.S. Certified Mail, this
10th day of October, 200E, to:

Donald R. Schieve, M.D.
1800 Highway 59
Bullhead City, Arizona 86442
Respondent


Copy of the foregoing mailed this
10th day of October, 2002, with:

Richard Abbuhl, Esq.
Robbins and Green

1 3300 North Central Avenue, Ste. 1800
2 Phoenix, Arizona 85012-2518
3 Attorney for Respondent

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6 1275 W. Washington, CIV/LES
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16 Board Operations
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